DD-214 (12-04)
P/P Ch.800

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

INDIVIDUAL SUPPORT PLAN (ISP) – COVER SHEET

NAME	DATE OF BIRTH	ASSISTS NO.	DATE

ADDRESS *(No., Street, City, State, ZIP)*	PHONE NO.

CURRENT RESIDENTIAL SETTING	EDUCATIONALLY PLACED (ARS15)	WORK, SCHOOL OR DAY PROGRAM
	☐ Yes ☐ No	

INCOME	TARGETED ELIGIBLE	TARGETED CONTACT TYPE	TARGETED FREQUENCY
☐ SSI ☐ SSA ☐ Other	☐ Yes ☐ No	☐ Phone ☐ In Person ☐ Letter	☐ 90 Days ☐ 180 Days ☐ Other

ALTCS ELIGIBLE	AHCCCS ID. NO.	VENTILATOR DEPENDENT	FOSTER CARE	EXTENDED FOSTER CARE
☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

AHCCCS HEALTH PLAN	PRIMARY CARE PHYSICIAN'S NAME	PRIMARY CARE PHYSICIAN'S PHONE NO.

THIRD PARTY LIABILITY	THIRD PARTY LIABILITY COMPANY NAME	POLICY NO.
☐ Yes ☐ No		

DENTAL COVERAGE	DENTAL POLICY CARRIER	DENTAL PHONE NO.	BEHAVIORAL HEALTH RECEIVED BY
☐ Yes ☐ No		(	☐ RHBA ☐ ALTCS PCP ☐ N/A

RESPONSIBLE PERSON *(Guardian)*	PHONE NO.

ADDRESS *(No., Street, City, State, ZIP)*

SUPPORT COORDINATOR'S NAME	ID NO.	PHONE NO.

LOCATION OF MEETING	REASON FOR TEAM MEETING
	☐ Annual Review ☐ Other *(Specify)*

COMMITMENTS AND SIGNATURES

All Team Members: I understand that my signature indicates participation in the development of this plan, and that I will carry out all responsibilities I have agreed to undertake in this plan. I understand that service decisions may require further approval, subject to ALTCS requirements or state funding. I understand a service provider may review the Division's client files for any historical and behavioral information per A.R.S. 36-557(L). **The grievance and appeal procedures have been explained to me.** If I am not satisfied with this plan and want to request an Administrative Review, I understand that I must request one within 35 days of the date of this plan. ***Support Coordinator*** I understand all team members must have the ISP mailed to them within 15 working days. ***Responsible Person Only:*** I understand that I may choose the Support Coordinator and Service Providers, subject to availability.

TEAM MEMBER'S NAME (Print)	RELATIONSHIP TO PERSON	TEAM MEMBER'S SIGNATURE	AGREE	DATE	DIVISION USE ONLY
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		

Equal Opportunity Employer/Program ♦ Under the Americans with Disabilities Act (ADA), the Department must make a reasonable accommodation to allow a person with a disability to take part in a program, service, or activity. For example, this means that if necessary, the Department must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that the Department will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if at all possible. Please contact 602-542-6825. ♦ Español en el reverso.